

Foreword

Building a bridge between two cultures of care

Integrating primary care and mental health care can benefit Asian patients

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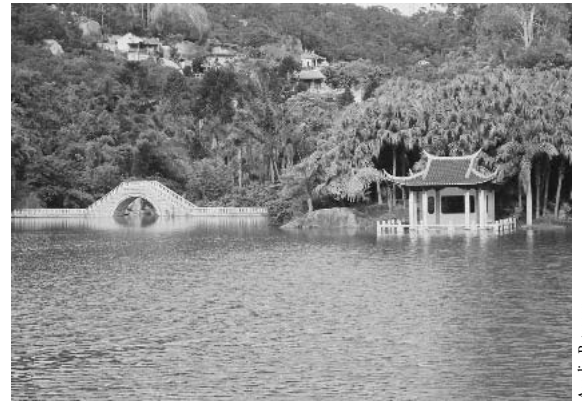
Building a bridge between primary care practitioners and their mental health colleagues is a major challenge today, especially in the care of patients who are immigrants from non-Western cultures. At The Charles B Wang Community Health Center (formerly known as CHC—Chinatown Health Clinic), an innovative program called the Primary Care and Mental Health Bridge Program is dismantling the barriers to mental health care experienced by Asian Americans. Asian Americans with mental disorders often do not receive treatment until they are chronically ill or in crisis. They suffer from a lack of access to mental health professionals, including providers fluent in Asian languages, and from the pervasive stigma of mental illness in traditional Asian cultures.

The Bridge Program is based on evidence showing the advantages of offering mental health services in a primary care setting. Katon and colleagues showed that such an approach could improve detection and clinical outcomes for primary care patients with major depression.¹ This finding is particularly important because primary care patients with mental disorders usually refuse treatment in specialty settings. More recent work by Wells and colleagues of the Partners in Care Program confirmed the benefits of bringing mental health services to multiple primary care settings.² A supplement to the *Surgeon General's Report on Mental Health* specifically cites the work of the Bridge Program and recommends that models like the Bridge Program be replicated to improve access and care for ethnic minority patients with mental health problems.^{3(p163)}

With the support of a Robert Wood Johnson Foundation Local Initiative Funding Partners grant, the Bridge Program demonstrated the efficacy of using the primary care setting as a major access point for behavioral health treatment.⁴ Key elements of the program are training primary care providers in the early detection and management of common mental disorders, educating the Asian community about mental health issues, and giving practitioners the communications tools to offer culturally responsive care.

Making mental health care accessible and acceptable in the Asian American community is not easy. Depression and other common mental health disorders are often masked as physical ailments by Asian patients, leading to misdiagnosis and less effective treatment. By training primary care providers to recognize the physical symptoms of mental illness, prompt and more appropriate care is possible.

As culturally sensitive physicians know, however, Asian



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American patients may not accept a behavioral health diagnosis. Traditionally, mental illness is seen as shameful for the individual and the family. The CHC model uses a practical new dialogue that respects the Eastern holistic definition of health. By focusing on the concept of the mind and body being in balance, primary care practitioners can explain that mental stress can cause physical symptoms. Treatment to restore balance is then the key to disease management.

Integrating behavioral and primary care into the same setting reduces the stigma that Asian patients may associate with seeking mental health services. Patients in the Bridge Program reported that they were more comfortable entering a primary care facility than a psychiatric one and less hesitant to return for mental health care appointments.⁴

Since the Bridge Program began, Asian American patients in psychiatric distress have received earlier diagnosis and treatment. Over a 3-year period, 1,905 individuals were seen for mental health treatment or education, resulting in 5,324 total mental health visits. Mental health visits by primary care providers had risen threefold over the 3 years. The total number of mental health clinical encounters and the number of patients in whom psychiatric disorders were diagnosed more than tripled at CHC's initial three sites during this time.⁴

Considering these results, the Health Resources and Service Administration selected the Bridge Program as a winner of the Models That Work program in 2000. This federal competition designates creative programs that respond to community needs, improve health outcomes for a vulnerable population, and can be replicated by other communities.

The RWJF Local Initiative Funding Partners program

also recognizes efforts that use innovative methods to deliver primary and preventive health care to underserved populations. Most importantly, these projects are expected to serve as new prototypes. Because of such results, the Bridge Program has been recognized as a prototype for other populations in other areas. Programs in Boston, Seattle, and Oakland have started to adopt the Bridge model.

Bridging primary and mental health care to better serve the Asian American community requires a serious training initiative, partnership with the community, and proactive primary care physicians. It is a useful model for all practitioners who care for Asian Americans and sets a new standard of integrated mental health and primary care.

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- 2 Wells KB, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. *JAMA* 2000;283:212-220.
- 3 Mental health, culture, race, and ethnicity. A supplement to *Mental Health: A Report of the Surgeon General*. Rockville, MD: US Dept of Health and Human Services; 2001.
- 4 *Models That Work, Compendium, Strategy Transfer Guide*. Rockville, MD: Bureau of Primary Healthcare, Health Services and Resources Administration, US Dept of Health and Human Services. In press.

The future of *wjm*

It is fitting that we have chosen the topic of improving the behavioral health care of Asian Americans for the last issue of *wjm* in the foreseeable future. *wjm* has a history of publicizing the health care needs of underserved populations, of featuring articles about cross-cultural care, and of recruiting authors who can write practical and valuable articles that can change clinical practice. We are grateful to our Guest Editors Henry Chung, Elizabeth Kramer, and Mack Lipkin and to the Robert Wood Johnson Foundation for their partnership in its creation.

Sadly, *wjm* has not found a way of being financially viable. Physicians no longer wish to pay for journals, neither do medical societies, and we have resisted becoming dependent on pharmaceutical advertising, which we feel influences and distorts medical journals. We will continue to work hard to find a way to publish *wjm* again in the future. For now, however, no subsequent issues of the journal are scheduled for publication.

I thank our loyal readers, our gifted authors, and a talented staff: Gavin Yamey, our Deputy Editor; Catherine Nancarrow, our Managing Editor; Auban Haydel, and Sherrie Prasad. Also, we have been fortunate to have the opportunity to work with some of the nation's best editors and advisors. We hope to be back soon. But until then, we wish you the best.

Michael Wilkes
Editor